Multidirectional eReferral Pilot Project: successes, lessons learned and plans to expand

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Land Acknowledgement

We want to acknowledge that our work today is done on traditional Dena'ina land, whose original people are the Dena'ina Athabascan people, one of Alaska's many distinct and diverse indigenous groups.

Generations of indigenous Native Alaskans created the Alaska that sustains us today. It is our hope that our work supports everyone's ability to thrive in their traditional homeland.

Dena'inaq elnen'aq' gheshtnu ch'q'u yeshdu. I live and work on the land of the Dena'ina. (Translation by Sondra Shaginoff-Stuart and Joel Isaak)



Location: Sunshine Community Health Center, 2 health centers, 7 school based health clinics: Upper-Valley



Sectors Represented: Connect Mat-Su's comprehensive referral hub offers hundreds of local, state and federal social referral services. The Alaska Tobacco Quitline offers comprehensive cessation services.



Project Participants: State of Alaska, SCHC, Connect Mat-Su (CM), TelAsk Technologies Inc



Funding: Project is currently funded in the pilot phase by the State of Alaska CDPHP



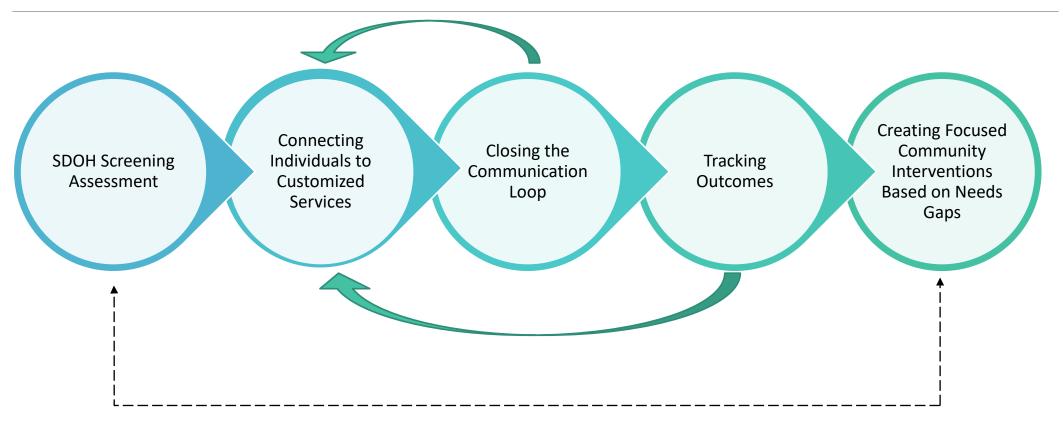
Launch Date: Planning took just over 1 year with a go-live of 5/1/2023



Integrated data platforms: Athena EMR, SalesForce referral platform, TelAsk QuitManager, Alaska Tobacco Quitline.

Project Snapshot

SDOH Bidirectional eReferral Concept Overview



Leveraging data to address regionally specific social needs gaps

Outside of Clinical Appointment

*SDOH referrals to Connect Mat-Su follow an "Opt-in" method meaning patients must elect to have their information sent to Connect Mat-Su

SDOH screening form is sent to patient or completed during intake registration SDOH data ingested into EMR as zCode **SDOH** data transferred to Connect Mat-Su via SFTP* Patient contacted by Connect Mat-Su, referrals coordinated

During Appointment

During intake, social screenings are confirmed by the MA.

New patients are automatically scheduled appointment with PT advocate for urgent social needs screening.

> PTs who deny social services, provider reinforces project value and offers referral

Follow up-Closing the Loop

SDOH outcomes

Transferred to EMR via SFTP as a closed outcome note.

> PTs with no follow upare sent to Advocate Inbox.

SCHC PT Advocates are alerted to note and provide additional services and follow up if needed.

Phase 2- Plans to Sustain and Replicate.

- 1. Refining the project to improve patient experience
- 2. Integration of HIE for sustainability
- 3. Replicate success within the Mat-Su valley service area and partner with SOA to identify ways to replicate project statewide.
- 4. Use data gathered to guide CBO service development in the Northern Valley.
- 5. Formal project evaluation and research with UAA